Applying Managed Fee-for-Service Delivery Models to Improve Care for Dually Eligible Beneficiaries

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The Medicare/Medicaid Integration Program

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The Foundation staff responsible for the program are: Nancy Barrand, Senior Program Officer; Pam Dickson, Senior Program Officer; James Knickman, Ph.D., Vice President for Research and Evaluation; and Diane Montagne, Program Assistant. The National Program Office (NPO) for the program is based at the University of Maryland Center on Aging under the direction of Mark R. Meiners, Ph.D. The NPO provides technical assistance and direction for the initiative. Rosalie Koslof is the Deputy Director for the program.

Information about the MMIP can be obtained from the following locations:
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New England States Consortium (NESC)

In May 1995, representatives of the six New England Medicaid programs met with representatives of the Health Care Financing Administration (HCFA) to discuss common issues and concerns. A major focus of attention was on the needs of persons eligible for both Medicaid and Medicare. Dually eligible persons include primarily older persons and persons with disabilities who utilize a significant portion of the state Medicaid resources even though they have extensive federal coverage under Medicare. Indeed, the states' representatives believe that the lack of integration between these two major health programs increases costs for both programs without necessarily improving care.

This simple meeting sparked the establishment of the New England States Consortium as an organizational structure "to coordinate activities related to the design, implementation, operation and management of a program for the delivery of comprehensive, coordinated care to persons who are dually eligible for Medicaid and Medicare" (*New England States Consortium, Memorandum of Understanding, 12/26/96*). The Consortium has several work groups to focus discussions between the member states and HCFA on specific issues.

For more information, contact:
Maureen Booth
New England Dual Eligibility Coordination Center
c/o Edmund S. Muskie School of Public Service, University of Southern Maine
96 Falmouth Street, Portland, ME 04104-9300
Website: http://nesc.muskie.usm.maine.edu
Phone: (207) 780-4430
Fax: (207) 780-4953

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This brief was prepared by **Stuart Bratesman** and **Paul Saucier** from the Muskie School of Public Service, University of Southern Maine. It was initially prepared for the New England States Consortium's Managed Fee-for-Service Workgroup, with support from the Robert Wood Johnson Foundation's Medicare/Medicaid Integration Program at the University of Maryland Center on Aging.

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Maureen Booth, Muskie School of Public Service, University of Southern Maine; **Kelley Capuchino**, New Hampshire Division of Behavioral Health; **Chad Cheriel**, Oregon Department of Human Services; **William Clark**, Division of State Program Research, Office of Research, Development and Information, Centers for Medicare and Medicaid Services; **Nancy Denu**, New Hampshire Division of Behavioral Health; **Pamela Gardner**, Massachusetts Division of Medical Assistance; **Elaina Goldstein**, Coordinated Services for the Elderly and Disabled, Rhode Island Department of Human Services / URI Partnership; **Joan Haslett**, Vermont Department of Aging and Disabilities; **Brendan Hogan**, Vermont Independence Project, Office of Vermont Health Access; **Michele Parsons**, Alternate Care Unit, Connecticut Department of Social Services; **Ellen Mauro**, Family Health Systems, Center for Adult Health, Rhode Island Department of Human Services; **Gino Nalli**, Muskie School of Public Service, University of Southern Maine; **Gillian Price**, ASAP Physician Program, Massachusetts Division of Medical Assistance; **M. Elizabeth Reardon**, Office of Vermont Health Access; and **Ellie Shea-Delaney**, Plans for the Elderly and Disabled, Massachusetts Division of Medical Assistance.

I. Background

In response to a turbulent risk-based managed care market, state and federal agencies are showing increasing interest in managed fee-for-service (MFFS) options to improve quality, maximize beneficiary independence, reduce fragmentation of care, and manage costs for Medicaid and Medicare beneficiaries. After nearly a decade of being eclipsed by the growth of risk-based Medicaid managed care, enrollment in primary care case management programs (PCCM) outpaced risk-based enrollment between 1998 and 2000. (Kaye, 2001) The Centers for Medicare and Medicaid Services (CMS) have launched a fifteen-site Medicare Coordinated Care demonstration and have been examining state PCCM experiences with an eye toward Medicare applications. (Sprague, 2001; Chen et al., 2000) The use of managed care techniques in fee-for-service Medicare (e.g.; prior authorization, concurrent review, provider selection, provider and consumer education, demand management) has been analyzed as a potential prong of Medicare reform. (Fox, 1998)

Since 1997, the Robert Wood Johnson Foundation's Medicare/Medicaid Integration Program has supported fourteen states to develop models of integrated care for dually eligible beneficiaries. During this period, many states have experienced a significant retrenchment of health plans from the Medicaid and Medicare managed care markets, requiring some states to rethink short-term implementation of fully capitated integration models. In some states, especially those with rural populations, managed care has never been an available Medicaid or Medicare alternative in all or in part of the state. Other states are continuing to develop fully capitated models while adding MFFS options for beneficiaries. The states featured in this paper (Maine, Massachusetts, Rhode Island, Oregon and Vermont) have all developed plans for or implemented MFFS models.

Many states have experience applying PCCM programs to Temporary Assistance to Needy Families (TANF) and State Children's Health Insurance Program (SCHIP) beneficiaries, and nearly half have enrolled beneficiaries who are elderly or have disabilities. However, most have excluded beneficiaries from any form of managed care if they are dually eligible, or if they are receiving community-based or institutional long term supports. (Kaye, 2001) For a variety of reasons, beneficiaries who are both dually eligible *and* require long term care are the most likely to be excluded from managed care as a matter of state and federal policy.

States exclude dually eligible beneficiaries because of their limited ability to influence the delivery of Medicare services. Without the ability to influence the use of hospital, emergency room, physician office visits and other Medicare-reimbursed services, states see little potential gain for beneficiaries and increased administrative costs for Medicaid. Furthermore, even if Medicare services can be influenced in a MFFS model, states currently have no mechanism to capture acute care savings that might offset the increased costs of care coordination.

These are significant but not insurmountable challenges. MFFS models are working to bridge the traditional gap between the Medicaid and Medicare systems by working closely with primary care physicians to coordinate their efforts with those of the traditional long term care delivery system. Many states believe Medicaid MFFS program costs can be offset with savings in nursing home costs and prescription drugs, but would welcome financial collaboration with CMS to share the costs and savings of MFFS programs that target dually eligible beneficiaries.

This brief identifies some of the features being implemented or contemplated in MFFS initiatives targeting dually eligible beneficiaries. Part II identifies features and organizes them into the following categories: Service Delivery, Quality, Payments and Data, with opportunities for state-CMS collaboration identified in each category. Part III of the brief describes the current efforts and status of MFFS initiatives in selected states.

II. Features of MFFS

Working Definition: Managed Fee-for-Service

We defined *managed fee-for-service* to mean *an arrangement in which quality and utilization are affected through greater payer-provider collaboration than in traditional fee-for-service programs, but most or all payments for services to beneficiaries remain fee-for-service with little or no insurance risk to providers. Payment arrangements can include bundling of certain services and incentives for high quality and efficient performance*. Managed fee-for-service includes, but is not limited to, primary care case management (PCCM) models. From the perspective of a State, MFFS implies an active management role in which the State Medicaid agency goes beyond the traditional claims payment role to affect quality and utilization.

When targeting dually eligible beneficiaries, the Medicaid agency can influence quality and utilization in areas where it plays a dominant role, such as prescription drug use or home and community-based long term support services, but the Medicaid agency's effectiveness will be greatly enhanced if, through collaboration with CMS, Medicaid and Medicare services can be considered together.

Service Delivery Features

In a fully capitated arrangement with a managed care organization (MCO) or provider organization, a state agency or CMS (or both) certifies that the MCO or provider organization has in place a comprehensive network that can deliver and coordinate all of the services specified in the contract. Specific arrangements with providers are the responsibility of the MCO or provider organization, and care coordination is generally provided directly by the organization or its subcontractors. In demonstrations targeting dually eligible beneficiaries, such as Minnesota's Senior Health Options program, integration of Medicaid and Medicare services is the responsibility of the MCO, with the State and CMS playing oversight roles.

In establishing a state-directed MFFS program (a PCCM program, for example), a state is acting much like an MCO or provider organization might act. It enters into contractual arrangements with selected providers, specifies a provider or agency to coordinate care, establishes enrollment criteria, conducts consumer and provider education, analyzes claims data, issues practice protocols, pays claims, etc. Many of these functions may be contracted to vendors (including MCOs, administrative service organizations and others) which act as agents of the state (e.g., in enrolling beneficiaries or processing claims). The state takes direct responsibility for integrating services through a series of interrelated contractual agreements or other mechanisms. This can often involve multiple state agencies, requiring close collaboration on policy development and program management. The major goals are similar to those of a fully capitated, integrated program:

- Streamline access for consumers to a range of services;
- Integrate primary, acute and long term support services;
- Improve quality; and
- Provide care in the most cost-effective manner possible.

States are experimenting with a number of MFFS delivery approaches. The following examples are not mutually exclusive. In fact, states appear to be combining approaches to develop MFFS delivery systems that build on state-specific strengths or preferences.

Primary Care Case Management (PCCM). In a traditional PCCM program, a primary care practitioner (PCP) agrees to be the care coordinator for enrollees, authorizing acute and specialty care and agreeing to be available for primary care. However, when serving dually eligible populations, States cannot empower the PCP to act as a gatekeeper for Medicare-covered services, nor can Medicare beneficiaries be required to participate in a program. As applied to dually eligible beneficiaries with long term support needs, the PCCM model may be enhanced to include the presence of long term care coordinators in primary care offices, or to expand feedback to PCPs to include information about both Medicare and Medicaid services. Maine and Vermont have created variations on PCCM programs for dually eligible beneficiaries.

Care Coordination. A central feature in all of the programs described in this paper is care coordination. States take various approaches to care coordination, but in every program described, integration of acute and long term support services is expected to occur through the coordination of care. Notably, most of the states discussed have existing care coordination or case management mechanisms for persons who need long term support services, but the existing care coordination generally does not systematically reach Medicare-funded services in general and physicians in particular. Thus several initiatives (such as Rhode Island's Level II CARRE Centers, Massachusetts' ASAP/Physician Program, Oregon's Care Coordination Pilot Projects, and the Vermont Independence Project) seek to strengthen their existing care coordination mechanisms by promoting ongoing, enhanced communication between their aging/disability networks and physicians. Another common problem that states seek to redress with MFFS initiatives is the phenomenon of having two or more care coordinators who do not routinely coordinate with one another. This can happen in Oregon, for example, where a beneficiary can have an Exceptional Needs Care Coordinator who focuses on services delivered through an Oregon Health Plan organization and a separate case manager for long term care who is based in the aging network. Where more than one care coordinator may exist, states are moving to designate a lead organization to convene care coordination teams that include all relevant persons, representing both social and medical needs. Beneficiaries and/or their representatives are members of the teams.

Chronic Care Management. Some states are borrowing concepts from disease management programs but focusing instead on multiple chronic conditions associated with both medical and functional needs. For example, Rhode Island's Connect CARRE program targets beneficiaries with multiple chronic conditions. Certain events (e.g., falls, repeated hospital admissions) trigger interventions that include intensive care management and consumer self-management education. The

State is identifying high risk and high cost beneficiaries through claims data and making their lead physicians aware of the program. Lead physicians may then invite beneficiaries to participate.

For dually eligible beneficiaries, states are limited in their ability to affect care through contractual agreements with providers. Clearly, the effectiveness of MFFS delivery systems would be enhanced through close collaboration with CMS. This might include joint administration of a PCCM program, for example, in which a PCP would have agreements to coordinate both Medicare and Medicaid services, and in which the state and CMS would establish joint program goals.

Quality Features

In MFFS, both the state and CMS can actively engage providers in quality improvement efforts. Again, the state acts as an MCO might, establishing quality goals directly with providers and supporting the achievement of those goals through provider education and data analysis. A state can stimulate quality improvements on its own in certain important areas within its control (e.g., prescription drug patterns), but clearly, the ability to influence the quality of overall care for dually eligible beneficiaries will be greatly enhanced through collaboration with CMS or with the Medicare Peer Review Organizations (PROs). The Rhode Island and Vermont dual eligibility projects have already initiated discussions with the Medicare PROs in their states to explore opportunities for collaboration on MFFS quality improvements. Quality activities within a MFFS initiative could include any of the following:

Establishing performance goals. These may include outcomes of particular relevance to dually eligible beneficiaries, such as increased utilization of community-based services, decreased utilization of nursing homes, clinical outcomes for conditions prevalent in the target group (e.g., heart failure or diabetes), and increased consumer satisfaction with services. Areas in which goals are not achieved might be selected for continuous quality improvement (CQI) projects on a statewide or regional basis.

Clinical protocols. The state may engage providers in the adoption of protocols for the treatment of certain prevalent conditions. A State's credibility to lead this type of quality initiative is dependent on strong clinical expertise in the form of a program medical director or medical consultant as well as a State's collaboration efforts with PROs. Massachusetts plans, in the long term, to train personal care homemakers to recognize significant indicators of health changes that should be reported to nurses or physicians immediately.

Provider education and feedback. This can include orientation to the MFFS program and its expectations, dissemination of written clinical resources (e.g., quality indicators for prevalent conditions), development of provider feedback reports from claims data, and consultation with the program medical director. Both the MaineNET* program and the Vermont Independence Project provide pharmacy utilization reports to PCPs. MaineNET plans to offer technical assistance to help PCP offices employ modern information systems to better manage care for patients with targeted chronic conditions. In Oregon, training will be provided for care coordination team members.

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* "MaineNET" will soon be renamed "MaineCare Services for the Chronic Care Population," in accord with the state's decision to consolidate the branding of all Medicaid-related services under one consistent "MaineCare" name.

Consumer education. Consumers may be provided with educational materials or programs on self-care and management for specific conditions, as envisioned in Rhode Island and Oregon. In the context of a voluntary program for dually eligible beneficiaries, consumers may also need more general education about the benefits of total care coordination and the risks of using providers outside the MFFS network.

Utilization review and prior authorization of services. Utilization review can be conducted with particular attention to the performance goals established for the program. Traditional review functions can be reoriented toward consumers who may need more than one service subject to prior authorization.

Some progress has already been made on state-CMS quality collaboration with the initiation of several projects targeting dually eligible beneficiaries through Medicare's peer review organizations (PROs). In a jointly administered MFFS program (or one in which CMS delegated authority to states) performance goals could be jointly established and monitored, joint CQI projects could be undertaken, and the clinical expertise of both state and federal agencies could be brought to bear in provider and consumer education efforts.

Payments

MFFS payment approaches seek to promote quality and efficiency without passing substantial insurance risk onto providers. Unlike capitation, MFFS incentives generally take the form of supplemental payments made to providers in return for additional contractual obligations (such as care coordination) or achievement of specific performance goals (such as immunization rates).

MFFS payment structures for programs targeting dually eligible beneficiaries are particularly challenging, given the constant threat of cost-shifting between Medicare and Medicaid. Also at issue is a state's ability to recoup whatever investments it makes in the administration of a MFFS program when Medicare is the payer for acute care services, where savings are most likely to accrue. Possible approaches include the following:

Utilization targets. By definition, these would not include any substantial insurance risk to providers, but failing to meet them could cause providers to forgo performance bonuses or trigger increased provider education or other corrective actions.

Supplemental fees. In a MFFS program, the state generally pays additional fees to providers in return for additional tasks. For example, primary care physicians generally receive a per-person per-month fee for coordinating care of enrollees. In PCCM programs targeting dually eligible beneficiaries, the fee is generally higher than for TANF or SCHIP beneficiaries, as acknowledgement that the coordination demands are greater. Some programs pay a higher fee for people who are certified to receive long term care than for those who are not.

Bundling. Some states are trying to achieve some of the benefits of capitation (service flexibility and budget management) by bundling certain services together. For example, Rhode Island plans to pay a fixed rate for the services of a multi-disciplinary care team, rather than paying each provider individually (social worker, occupational therapist, nurse, etc.). In deciding what to bundle, states should be aware of any unintended incentives that might be established, and create payments that support utilization

goals. For some states, bundling a group of services might be a first step toward a partially or fully capitated payment system.

Opportunities to collaborate with CMS on MFFS payments include sharing the costs of care coordination PCCM fees* and other program costs, sharing savings across Medicaid and Medicare, and establishing joint Medicaid-Medicare utilization targets to avoid cost shifting.

Use of Data

Managed fee-for-service assumes that a state or CMS compiles, analyzes and acts on program data as an important quality measurement and care management tool. Potential sources of data include Medicaid and Medicare claims and eligibility files including HCBS waiver data, community and nursing home long term care assessment files, state-funded pharmacy and long term care program claims, Older Americans Act program information, and the MFFS program's own screening and assessment tools. Applications include the following:

Research. States can use data from claims, assessments and eligibility files to conduct research to support a MFFS program. This can include, for example, clinical research to determine whether beneficiaries with targeted conditions have received care in accordance with accepted standards. It can also include cost and utilization studies to better understand the patterns of target groups. Longitudinal databases can be used to detect patterns of care leading to nursing home use or other preventable hospital admissions. In recent years, CMS has collaborated with several states by providing them with Medicare claims, allowing states to develop a comprehensive view of the services used by dually eligible beneficiaries.

However, CMS has been reluctant to provide all Medicare claims to states except where specifically needed to carry out proposed research projects. Longitudinal studies that focus on transitions of beneficiaries from Medicare-only status to dual eligibility require access to claims data for the Medicare-only population.

Assessment data that measures frailty, the need for assistance with activities of daily living and the need for long term care services can help in the design of service delivery systems aimed at integrating primary, acute, and long term care. However, some state Medicaid programs have faced technical and administrative challenges in obtaining access to assessment data collected by other state government agencies.

Program Management. Timely review and analysis of claims data and development of reports to providers are key elements of MFFS initiatives. Until very recently, states have not been able to access current Medicare claims for this purpose. However, CMS and Maine have found ways to make this possible in the MaineNET program by increasing the number of types of claims reported by Medicare carriers and intermediaries to State Medicaid agencies through the existing Medicare cross-over claims

* Due to the amount of paperwork required, physicians in several states have reported a reluctance to bill CMS for the currently available Medicare Care Plan Oversight (CPO) fees for hospice and home health patients who require complex or multidisciplinary care. To bill for those fees, physicians must maintain documentation demonstrating that twelve different billing criteria were met. (Fee Schedule for Physicians' Service, 2001)

system. By utilizing the Medicare cross-over claims, States can obtain Medicare procedure and diagnosis data within weeks or months of the date-of-service instead of waiting a year or more for historical linked data files. CMS is also collaborating with Oregon, Washington, and Rhode Island to pilot a new data system that would allow States to electronically access CMS' own Medicare claims data for dually eligible beneficiaries as quickly as CMS receives it. Without timely Medicare data, a state has no way of knowing whether cost shifting is occurring or of monitoring utilization of services delivered in settings outside the PCP's practice.

Evaluation. States and CMS can use existing and collected data to establish baseline measures against which a program's goals can be evaluated. Data for program participants and control groups can be used to compare changes in performance indicators over time, and changes in Medicaid and Medicare costs. Evaluation is particularly important given the untested nature of MFFS approaches for dually eligible beneficiaries.

Stepping Stone or Alternative to Fully Integrated Approaches?

Managed fee-for-service approaches offer the potential to improve care for dually eligible beneficiaries, but their effectiveness is still untested. Many of the states that are implementing or considering MFFS programs for dually eligible beneficiaries have tried to launch fully integrated, capitated programs but have been frustrated by inadequate or unwilling managed care organizations and by constituents who are increasingly wary of managed care. For these states, the status quo of fragmented and costly fee-for-service is unacceptable, and MFFS offers a viable place to start. With some careful evaluation, the benefits and limitations of MFFS will become known over time, as will the feasibility of gradually converting MFFS initiatives into fully integrated programs.

Chart 1: Features of Managed Fee-For-Service Approaches to Dually Eligible Beneficiaries

	Service Delivery	Quality	Payments	Data

MFFS can include:	• PCCM
	• Care Coordination
	  ◆ Partner concept for integrated delivery
	  ◆ Teams
	• Chronic Care Management
	  ◆ Certain targeted chronic conditions
	  ◆ Certain levels of functional impairment
	  ◆ Triggering events
	• Mental Health Management
	• Interagency Collaboration
	• Combinations of above
		• Targeted performance goals (e.g.; access, utilization, clinical, satisfaction)
		• Clinical protocols
		• CQI projects
		• Provider education and feedback
		• Consumer education
		• Utilization Review
		  ◆ Person centered, rather than service centered;
		  ◆ Prescription drug reports
			• FFS Reimbursement
			• Targets/caps on utilization (but little or no insurance risk to providers)
			• Supplemental fees for coordination and other value-added activities
			• Bonus payments tied to performance measures
			• Bundling for service flexibility
				• Research through linking and analysis of:
				  ◆ Medicaid claims;
				  ◆ Medicare claims;
				  ◆ Assessment data;
				  ◆ State program data;
				  ◆ Older Americans Act program data;
				  ◆ Surveys and self-reports
				• Operations:
				  ◆ reports to providers;
				  ◆ performance data
				• Program planning and evaluation.

State-CMS collaboration opportunities to improve care for dually eligible beneficiaries:	• Joint administration
	• CMS delegation of program authority to state
	• Improved benefit coordination within existing Medicare and Medicaid frameworks
		• Joint quality initiatives across Medicare and Medicaid
		• PRO projects on dually eligible beneficiaries across settings
			• Share cost of fees and bonuses
			• Share savings
			• Establish utilization targets collaboratively to avoid cost shifting
			• CMS delegation of payment authority to states
				• Clarify and streamline data sharing protocols
				  ◆ Share historical data for research, planning and evaluation;
				  ◆ Share current data for program operations;
				  ◆ Share analyses

III. Description of Selected Managed Fee-for-Service Projects

Massachusetts

The Massachusetts Division of Medical Assistance (the Division) and the Executive Office of Elder Affairs (Elder Affairs) are designing a geographically based pilot project, the ASAP-Physician Program, to improve the coordination of community long term care (LTC) and medical services for dually eligible and Medicaid-only seniors.

The program planners believe that by enhancing communication between health and social support providers and encouraging partnerships between physicians and the aging network (through Aging Services Access Points, or ASAPs), eligible beneficiaries will achieve better health outcomes. The program aims to:

- improve the coordination of primary, acute and community long-term care;
- introduce new strategies to maintain seniors' optimal functional status, increase early identification of conditions that lead to acute events and improve access to community-based long term care services, and
- support and enable seniors to live in the community as long as appropriate.

The ASAPs will take a lead role to help make physicians more aware of local and regional long term care resources. ASAPs and physicians will meet and work together to improve communication and coordination with a key goal of reducing the number of avoidable nursing facility admissions. A long term goal is to train personal care homemakers to look for signs of deterioration and for symptoms of targeted diseases and report them to their home care agency or to the member's primary care physician. Participating doctors will receive data including pharmacy quality indicator reports, prescribing patterns, and medication utilization.

Seniors served through this program will continue to access needed Medicare and/or Medicaid covered services under the traditional fee-for-service program(s) and ASAPs will purchase state-funded Home Care Program services according to the current criteria. In the future, the program may be expanded to include low-income Medicare-only seniors. These Medicare-only seniors will be enrolled in the Enhanced Community Options Program (ECOP), which means they receive enhanced levels of services as state resources allow. In addition to the regular fee-for-service payments, the Division (Medicaid) will contract with Elder Affairs to make coordination payments to participating ASAPs and pay a monthly coordination fee directly to participating physicians.

Maine

The MaineNET dual-eligibility MFFS project began on a pilot basis in July 2000. The program, which currently operates with one physician group practice in Houlton and two groups in Skowhegan, accepts voluntary registrations from community-dwelling dually eligible beneficiaries and Medicaid-only adults with disabilities. The participating primary care physicians coordinate primary and acute care services for their MaineNET patients. These doctors receive a five-dollar per member per month fee for each

MaineNET member. All regular Medicaid and Medicare services are reimbursed on a fee-for service basis.

As the program enters its second year, MaineNET staff are changing or redesigning certain elements based on the lessons learned during the first year of operation. In the initial phase, physicians received detailed 12-month pharmacy utilization reports for each MaineNET member. These reports have been simplified, and members will now receive a copy, every three months, when report updates are sent to their primary care physician. The physician's version of the reports will also contain individually tailored advice on improving prescribing practices for elderly patients and patients with disabilities. The MaineNET project may also incorporate occasional consulting sessions between MaineNET primary care physicians and an expert pharmacist.

During the first year of the program, members who were also enrolled in Medicaid waiver or state-funded home and community based long term care (LTC) services were designated as "Partnership" members. Partnership members were assigned a Care Partner, a nurse or social work LTC case manager who was co-located in the physician group practice office. Care Partners were assigned to meet in-person with Partnership members, and to work with physicians to help integrate medical and LTC services. However, even at lower-than-expected Partnership enrollment levels, the Care Partners were overwhelmed by the workload and time-demands created by the open access afforded to Partnership members. As a result, the Care Partners have been replaced by the regular LTC case managers who contact beneficiaries and LTC service providers by phone from a central statewide office. Beneficiaries who had been designated as Partnership members are now designated as regular MaineNET members.

This one-on-one approach has been replaced by a population-based approach in MaineNET's second year. MaineNET has created a Program Manager position to create and coordinate interventions targeted for members diagnosed with specific chronic conditions, including congestive heart failure, cardiovascular disease, diabetes, and risk of falls. These interventions include:

- a quarterly summary pharmacy report on each member for PCP review
- quarterly pharmaceutical quality indicator reports aggregated at the group practice level
- chronic disease management tools for participating practices
- targeted participant mailings with patient education materials, self-management strategies and chronic care management prompts
- identification and cataloging of community specific resources for physician practices
- provision of "academic detailing" support to participating physicians vis-à-vis consulting pharmacists, Program Medical Director and Program Manager
- identification of individuals at highest risk for falls through a triage process of claims data

Oregon

The Oregon Senior and Persons with Disabilities Services (SPDS) office is developing a Care Coordination Pilot Project that enhances existing case management services through the creation of Care Coordination Teams (CCTs). Participants will include dually eligible and Medicaid-only elderly persons and adults with disabilities who enroll voluntarily after meeting the following criteria:

- do not receive primary case management services from Oregon's Mental Health and Developmental Disabilities Services Division; and
- have multiple chronic conditions; or
- are high utilizers of acute care services; or
- are at high risk for high utilization of medical or long term care services.

The pilot will begin in four sites across two counties. Each site is expected to recruit and enroll about 50 consumers. The pilot project aims to improve consumer and provider satisfaction, reverse or reduce declines in health and functional status, and increase collaboration and coordination between medical providers, long term care providers, formal and informal caregivers, and consumers.

The team coordinating care for any given consumer will include the consumer or surrogate representative, formal and informal caregiver(s), case manager, Contract Registered Nurse (CRN), physician, and an Exceptional Needs Care Coordinator (if the consumer is enrolled in a Medicaid managed care plan). If necessary, teams may also involve additional members including a case aid, home health nurse, discharge planner, specialists or geriatric experts.

Once teams have been recruited for the project, SPDS will offer monthly training seminars on team coordination, assessment, care planning, disease management, self-management, and other topics. In addition to improving coordination between individual team members, the team will also foster patient education, consumer self-management of services and chronic conditions, and greater consumer and family involvement in making care decisions. Teams will develop detailed care plans for each consumer, based on a full assessment by the CRN and on the preferences expressed by consumers and family members who will be directly involved in the care planning process.

SPDS will evaluate the program by using data from claims data, the periodic client assessment tool, and consumer and provider surveys to determine:

- changes in measured and self-perceived health and functional status;
- changes in medical and long term care risk measures;
- changes in satisfaction among consumers, family members, informal caregivers and team members;
- degree of consumer care self-management and care plan compliance;
- degree of collaboration between team members;
- attitudes toward collaboration;
- changes in rates of admission to hospitals, nursing facilities, emergency room use and costs.

Consumer outcomes and service utilization measures at each site will be compared to the other sites and to control groups of similar non-participating consumers in the same or neighboring counties. Differences in outcomes between sites will be analyzed in light of the differences in types of collaboration documented at each of the four pilot sites. The lessons learned from the evaluation will the used to shape the types of teams developed if and when the care coordination team model is replicated in other sites.

Long term care services will continue to be paid by Medicaid and Medicare on a regular fee-for-service basis, except for the services of the Contract Registered Nurses, to paid by SPDS. Acute care and other medical services will be paid on a fee-for-service basis, or by capitated payments, if the consumer

is enrolled in a Medicaid managed care plan. SPDS will also pay for the monthly training sessions, and the costs of data collection and analysis.

Rhode Island

The Rhode Island Department of Human Services Center for Adult Health is developing Living Rite, a three-tiered system, based on level-of-need, for organizing the delivery of services to adults with long term care and chronic care needs. Two of these tiers, the Level II CARRE (for Coordinated Assessment, Referral, Re-Assessment, and Evaluation) Center, and the Level III Connect CARRE program employ a MFFS approach. The Level II CARRE Center program is meant to improve and formalize the coordination of existing long term care, social, and medical services for frail adults and elders whose needs are primarily long-term care related. The Level III Connect CARRE program aims to develop new care coordination teams for the elderly and adults with disabilities who have multiple chronic conditions or are at high risk for high utilization of medical and other services.

Level II CARRE Centers

The Level II CARRE program, currently in planning, will be targeted toward community-dwelling adults and elderly persons whose primary needs are related to long term care and functional status. Enrollment will be voluntary and eligibility will be based on the level of frailty measured by a Minimum Data Set for Home Care (MDS-HC) in-home assessment.

Any care management organization, health system, or long term care provider that meets the State's certification standards can apply to be designated as a Level II CARRE Center. The Centers will provide each consumer with a social worker or nurse care manager to help consumers navigate the long term care and social services system. These services will be provided or contracted for by the CARRE Center. The care manager will also collaborate with each consumer's primary care physician, and sometimes with a nurse, to coordinate long term care with medical and mental health care. In addition to improving service coordination, care managers will also perform or arrange for additional in-home MDS-HC assessments to help update the consumer's individualized care plan every six months, or more often, when needed.

CARRE Centers will develop their own quality improvement programs and set of quality indicators, with State approval. Level II QIs must address core services, care process improvement strategies, and level of coordination with other systems. Payments for LTC and medical services will continue on a fee-for-service basis. However, payments for services related to care coordination may be packaged. The State may offer enhanced payments to CARRE Center for achieving outcomes measure goals as determined by the analysis of data from the State's LTC information management system, and linked Medicaid and Medicare claims data.

Level III Connect CARRE

The Level III Connect CARRE program is designed to identify consumers with declining health status and frequent illness and link them to community support services through a team of providers and care coordinators including a Lead Physician. The program will assist consumers and their families to manage chronic illness by helping them develop a consistent and supportive relationship with a physician

and a Nurse Care Manager. The program will also identify and coordinate community-based services and care resources that can assist consumers in maintaining wellness and reducing recurrent illness.

The Connect CARRE program is voluntary and available to community-dwelling individuals age 22 and older with a specified disability or chronic disease, if they are at-risk for frequent hospitalizations and emergency room visits, and if they lack social and community supports.

Medicaid consumers are generally referred to this program by a letter of invitation from their community-based physician. The consumer is assigned a Nurse Care Manager who performs a complete health assessment in the home and then develops a plan of care with the consumer and their physician. The nurse is available to the consumer and acts as an advocate to take advantage of programs, services and benefits to which the consumer is entitled.

The Program is an integrated approach to health care delivery and coordination across the continuum. It is designed to improve wellness, care coordination and health outcomes and reduce unnecessary acute care by:

- Identifying and proactively care managing a high risk population;
- Assisting consumers and providers in creating and following an individualized plan of care;
- Improving provider communication and collaboration;
- Assisting consumers to manage their own care by improving education about their specific disease and how to advocate for themselves; and
- Promoting consumer compliance to avoid adverse medical events.

The program has specific goals and outcomes based on the individual's chronic diseases, including: diabetes; asthma; chronic lung disease; congestive heart failure; depression; sickle cell anemia. The program aims to improve the health status and well being of participants.

The program is aimed at reducing high-cost, multiple readmissions among a target population of Medicaid-only, chronically ill adults over age 21. Nurse care managers, contracted from an HMO, will coordinate acute care, home care and self-help. The HMO would be paid a per member management fee including administrative costs, social service and pharmacy consultation fees, in a team approach to care planning. At a future date, the program may explore the applicability of a partial capitation-based reimbursement system.

The program will use the MDS for Home Care, PRA Plus and SF-36 screening tools to complete a functional assessment as well as identify members at high risk for hospitalization. When members are hospitalized, the nurse case manager will coordinate discharge planning with the patient's primary care or specialist lead physician to reduce the number of discharges to nursing homes.

The program will also collaborate with a network of community agencies to provide home and community based services. Savings from reduced hospitalization and institutionalization will be reallocated to increase the availability of HCBS services. Enrollment began in November 2001.

Vermont

Vermont has two MFFS projects. The Vermont Independence Project's Care Partner pilot program began in March 2001. Seven primary care practices in Franklin, Grand Isle and Windham counties in

Vermont have volunteered to participate in this pilot program. Council on Aging Case Management staff have established office hours at the participating primary care physician's (PCP) offices as "Care Partners" to assist with care coordination for Medicare and Medicaid dually eligible Vermonters. Voluntary participants in this program will be divided into two groups:

- Level one participants who have both Medicare and full Medicaid benefits; and
- Level two participants who have Medicare and less than full Medicaid benefits (i.e. eligible by virtue of QMB, SLMB status or participation in a pharmacy program).

Referrals to this program will come from the participating PCP offices. PCPs will continue to provide primary and acute care services and will participate with both the client and Care Partner in developing and implementing a care plan. This care plan will include both the client's medical and social service needs. The Care Partner will assess the client's needs by using an ILA or Individual Living Assessment tool. This tool assists the Care partner in determining both the client's functional status and the level of services necessary for the client to remain in the community. A quarterly pharmacy report will be created for all participants. Both the PCP and the Care Partner will assist in coordinating the clinical and social service aspects of their client's pharmacy needs. Medicare and Medicaid services will all be reimbursed on a fee-for-service basis. This program strives to control costs and improve quality through enhanced care coordination.

Vermont's second project is the Primary Care Case Management program or PC Plus. PC Plus was implemented in October 1999 for the following: traditional Medicaid members, Vermont Health Access Plan (VHAP) members and aged, blind and disabled members. As of December 31, 2000 there were 63,000 members enrolled in PC Plus. PC Plus is established and operates under an 1115 waiver approved by the Health Care Financing Administration (HCFA).

The objectives of the program are to: enhance the health status of the individuals with chronic disabling conditions by providing a unified point of service coordination, maximize dollars spend for care versus those on administration, allow for increased consumer involvement in his/her plan of care, establish a partnership between the State and community providers to jointly develop coordinated care programs specifically targeted towards the needs of the enrolled population. PCP's continue to provide primary and acute care services and are reimbursed on a fee-for-service basis. PCP's receive $5 per month for every PC Plus patient and $40.80 per member per year for developing and implementing a treatment plan in accordance with guidelines from OVHA. This program aims to control costs, remain budget neutral for the 1115 waiver, and improve quality outcomes for its members by creating a "medical home" at the participating PCP's office where services are either provided or coordinated for all members.

Chart 2. Managed Fee-for-Service Approaches to Dually Eligible Beneficiaries in Selected States

	Target Population	Service Delivery	Quality	Payments	Data
Maine ***MaineNET*** (implemented July 2000)	• Dually eligible and Medicaid-only adult beneficiaries with disabilities who have: LTC needs; CHF; diabetes; cardio-vascular disease; cog. impairment, or other targeted conditions	• PCCM model • Targeted interventions for chronic conditions (DM, CHF, CVD & falls prevention)	• Quality indicators • Patient education and self-management • Physician education • Pharmaceutical academic detailing	• Fee-for-service • Physicians paid $5 per member per month care coordination fee	• Pharmacy reports to providers & members • Linking and analysis of Medicare & Medicaid claims data • Pre-post evaluation of members & control group
Massachusetts (target date 2002)	• Dually eligible, Medicaid-only, and potentially other low-income Medicare-only and elders.	• Coordinate doctors and aging network	• Pharmacy indicator reports provided for physicians • In the future, train personal care aides and homemakers in early identification of precursor conditions	• Fee-for-service for medical and LTC • Monthly enhanced coordination fee for doctors and contracted aging network agencies	• Linking and analysis of Medicare & Medicaid claims data • Performance indicator data • Program evaluation data

	Target Population	Service Delivery	Quality	Payments	Data

Oregon
Care Coordination Pilot Projects
(in planning)
	• Dually eligible and Medicaid-only beneficiaries with LTC needs, including elderly persons and other adults with disabilities. Within this group:
	  • Persons with chronic care needs and others with high cost utilization will be targeted;
	  • Persons who receive primary case management through mental health or developmental disabilities systems are excluded.
		• Coordination of social and medical services through a Care Coordination Team (CCT) with case manager, RN, consumer, caregivers, physician, ENCC, and others[1]
		• Participants will be selected locally through participating case managers. State will provide list of individuals who meet target criteria. Participation voluntary for consumers.
		• Initially 4 sites of 50 consumers each. (3 in Multnomah and 1 in Washington County)
			• Coordination training and protocols
			• Consumer self-management of chronic care
			• Quasi-experimental evaluation addressing consumer, team and system outcomes
				• Services continue to be reimbursed as in current system[2] .
				• State will cover initial and ongoing training needs
				• State will provide Contract Registered Nurse (CRN) hours to sites, which may be used in part to collect data
					• Coordinated record system, including detailed care plan, to track interventions
					• Outcomes data from existing sources, including CAPS (care planning assessment tool), State surveys of consumers and providers, claims and eligibility files.

[1] Exceptional Needs Care Coordinators (ENCCs) are assigned by health plans to certain persons enrolled in Oregon Health Plan managed care plans. Other possible members of the Care Coordination Team include case aides, home health nurses, discharge planners and others.

[2] Oregon pays for Medicaid services in a variety of ways, depending on the needs and location of the consumer. Long term care is generally FFS and acute care is generally capitated, though many consumers with long term care needs are enrolled in a primary care case management (PCCM) option for primary and acute care.

	Target Population	Service Delivery	Quality	Payments	Data

Rhode Island
Connect CARRE
(implemented November 2001)
	• Dually eligible and Medicaid adult and elderly beneficiaries with:
	  • declining health status;
	  • history of falls; or
	  • repeated hospital admissions
		• Care team with lead physician & nurse care manager coordinates with LTC providers
		• Nurse CM coordinates hospital discharge planning
			• Nurse in-home assessment w/MDS-HC, PRA+, SF-36
			• Support chronic care self-management
			• Measure:
			  • Consumer & physician satisfaction
			  • Change in functional status
			  • Change in acute care utilization
			  • Chronic condition-specific outcomes
				• Fee-for-service
				• May explore future partial capitation option
				• Program savings invested in home & community-based service expansion
					• Linking and analysis of Medicare & Medicaid claims data

Level II CARRE Centers (in planning)	• Frail dually eligible and Medicaid adult and elderly beneficiaries with LTC needs determined by MDS-HC assessment	• Social worker or nurse CM at the CARRE Center coordinates LTC and social services provided or contracted by the CARRE Center • CM collaborates with consumer's primary care physician to coordinate medical with other services • For some consumers, CM may also coordinate with a nurse	• In-home assess-ment w/MDS-HC every 6 months • Each CARRE Center to develop own QIs for core services, care process improve-ment, and degree of coordination with other systems. QIs to be approved by the State	• Fee-for-service • Payments for care coordination services may be packaged • Program may offer enhanced payments to CARRE Centers for achieving outcomes measure goals	• Linking and analysis of LTC data management system and Medicare & Medicaid claims data

	Target Population	Service Delivery	Quality	Payments	Data
Vermont ***Vt. Independence Project*** (implemented March 2001)	• Dually eligible beneficiaries	• "Care Partner" care managers have office hours at doctor's office • Doctor & CP develop care plan	• Medical/LTC full assessment • Quarterly pharmacy report	• Fee-for-service • Coordination fee for Care Partner organizations	• Linking and analysis of Medicare & Medicaid claims data • Medicaid pharmacy data
Primary Care Plus (implemented October 1999)	• Medicaid beneficiaries and Vermont Health Access Plan members who are elderly or adults with blindness or other disabilities.	• PCCM 1115 waiver program • unified point of service coordination by doctor • consumer involved in care planning	• Improve quality by creating stronger relationship between each consumer and a single primary care physician office	• Fee-for-service • $5 PMPM coordination fee for doctors, plus $40.80 per member annual fee for care planning	• *Under discussion*

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Appendix: Summary of opportunities for State – CMS collaboration

This appendix presents a summary list of the opportunities for collaboration between the States and CMS within the context of managed fee-for-service (MFFS) approaches for improving medical and long term care for dually eligible beneficiaries. The numbers within parentheses refer the reader to the page on which each idea appears in the text.

- Financial collaboration with CMS to share the costs (including primary care physician fees for enhanced care coordination and case management) and to share the savings of MFFS programs that target dually eligible beneficiaries (page 2)
- Joint state and CMS administration of a Primary Care Case Management (PCCM) program in which a primary care physician (PCP) would have agreements to coordinate both Medicare and Medicaid services, and in which the state and CMS would establish joint program goals. (page 5)
- Collaboration between States and CMS or the local Medicare Peer Review Organization (PRO) to establish joint quality monitoring systems and joint quality improvement goals across the span of Medicare and Medicaid services (page 5)
- Joint agreements between States and CMS to create clinical protocols for the treatment of chronic conditions (page 5)
- CMS could continue its current efforts to improve State access to timely Medicare claims data for dually eligible beneficiaries and review its recent decision to restrict State access to individually identifiable Medicare claims data for Medicare-only populations, especially those Medicare-only populations at higher risk of also becoming Medicaid eligible. (page 7)
- CMS and States could collaborate on the design of evaluations of MFFS projects to improve care for dually eligible beneficiaries. These evaluations could measure changes in quality and performance indicators over time, changes in service utilization, and change in Medicare and Medicaid costs. (page 8)